

TITLE 28. INSURANCE

PART 2. TEXAS DEPARTMENT OF INSURANCE, DIVISION OF WORKERS' COMPENSATION

CHAPTER 134 - BENEFITS--GUIDELINES FOR MEDICAL SERVICES, CHARGES, AND PAYMENTS

SUBCHAPTER G - PROSPECTIVE AND CONCURRENT REVIEW OF HEALTH CARE

28 TAC §134.600

ADOPTION

1. INTRODUCTION.

The Texas Department of Insurance (Department), Division of Workers' Compensation (Division) adopts amendments to 28 TAC §134.600, concerning preauthorization, concurrent review, and voluntary certification of health care. The amendments are adopted with changes to the proposed text as published in the December 30, 2011, issue of the *Texas Register* (36 TexReg 9192).

These amendments are necessary: (1) to harmonize §134.600 with other Division rules and policies, Chapter 504, Labor Code, and certain provisions of Chapters 1305 and 4201, Insurance Code; and (2) to make other changes necessary to clarify the implementation and application of this section. The Division adopts these amendments in conjunction with its adopted amendments to 28 TAC Chapter 133 (relating to General Medical Provisions) published elsewhere in this issue of the *Texas Register*.

In accordance with Government Code §2001.033(a)(1), the Division's reasoned justification for this rule is set out in this order, which includes the preamble and rule. The

preamble contains a summary of the factual basis of the rule, a summary of comments received from interested parties, names of those groups and associations who commented and whether they were in support of or in opposition to adoption of the rule, the reasons why the Division agrees or disagrees with some of the comments and recommendations, and all other Division responses to the comments.

No public hearing was requested or held for this proposal. The public comment period closed on January 30, 2012, and the Division received 12 public comments.

2. REASONED JUSTIFICATION.

On December 5, 2011, the Division withdrew its proposed amendments to §134.600, which were published in the July 29, 2011, issue of the *Texas Register* (36 TexReg 4783). The Division determined this withdrawal was necessary because the primary purpose of those proposed amendments was to harmonize §134.600 with the amendments to 28 TAC §§19.2001 - 19.2017 and §§19.2019 - 19.2021 (relating to Utilization Reviews for Health Care Provided under Workers' Compensation Coverage) (Subchapter U) proposed by the Department in the July 8, 2011, issue of the *Texas Register* (36 TexReg 4344). On November 21, 2011, however, the Department withdrew these proposed amendments to Subchapter U and announced that it would be issuing new informal draft rules on the same topic at a later date. In light of this withdrawal and announcement, the majority of the Division's proposed amendments to §134.600 became premature and were, therefore, withdrawn.

The Division also elected, however, to repropose the July 2011 amendments to §134.600 that did not relate to the Department's proposed amendments to Subchapter U.

Those proposed amendments and other new amendments to this section were published in the December 30, 2011, issue of the *Texas Register*. The amendments, as stated above, are necessary to: (1) harmonize §134.600 with other Division rules and procedures, Chapter 504, Labor Code, and certain provisions of Chapters 1305 and 4201, Insurance Code; and (2) make other changes necessary to clarify the implementation and application of this section. The amendments also make non-substantive changes to this section to conform to current nomenclature, reformatting, consistency, clarity, and to correct typographical and/or grammatical errors.

The Division adopts these amendments with changes from the December 30, 2011 formal proposal. First, the Division has, in response to comment, amended subsection (u) to provide that “all utilization review agents or registered insurance carriers who perform utilization review under this section must comply with Labor Code §504.055 and any other provisions of Chapter 19, Subchapter U of this title (relating to Utilization Reviews for Health Care Provided under Workers' Compensation Coverage) that relate to the expedited provision of medical benefits to first responders employed by political subdivisions who sustain a serious bodily injury in course and scope of employment.” This change is necessary to ensure that this section remains in harmony with any future rules issued by the Department on this topic while still requiring all applicable parties to comply with Labor Code §504.055.

Second, the Division has, in response to comment, added new §134.600(v) that incorporates a delayed effective date for this section of July 1, 2012. This delayed effective date is necessary to ensure that parties have sufficient time to evaluate and implement the new requirements of these amendments.

3. HOW THE SECTION WILL FUNCTION.

Amended §134.600(a). The adopted amendment to §134.600(a)(4) clarifies that a Division granted exemption for work hardening or work conditioning programs from preauthorization and concurrent review requirements only extends to services that are consistent with the Division's treatment guidelines. This amendment is necessary to harmonize this definition with the Division's clarifying amendments to §134.600(p)(4) and (q)(2), which provide, respectively, that preauthorization or concurrent review is required for all exempted work hardening or work conditioning programs if the proposed services will exceed or are not addressed by the Division's treatment guidelines.

Amended §134.600(f). The adopted amendments to §134.600(f) provide that requests for preauthorization must now also include the name of the injured employee; the name of the requestor and requestor's professional license number or national provider identifier, or injured employee's name if the injured employee is requesting the preauthorization; the name and professional license number or national provider identifier of the health care provider who will render the health care if different than the requestor; and the facility name and the facility's national provider identifier, if applicable. These amendments are necessary for proper identification of all parties to the request and to ensure the appropriate review of the request.

Amended §134.600(o). The adopted amendment to §134.600(o)(1) extends the deadline for a requestor to submit a request for reconsideration after receiving denial of a preauthorization request from 15 working days to 30 days. This amendment is necessary to harmonize this requirement with the parallel requirement for network claims under Insurance Code §1305.354, which provides requestors 30 days to submit a request for reconsideration.

The adopted amendment to §134.600(o)(2) extends the deadline for an insurance carrier to respond to a request for reconsideration of a denial of a preauthorization request. The deadline is extended from “within 5 working days of receipt of the request” to “as soon as practicable but not later than the 30th day after receiving a request for reconsideration.” This requirement is necessary to comply with Insurance Code §4201.359, which provides that a utilization review agent’s procedures must provide that it will respond to an appeal of an adverse determination “as soon as practicable but not later than the 30th day after receiving a request for reconsideration.” This amendment also harmonizes this requirement with an analogous requirement for network claims under Insurance Code §1305.354, which provides insurance carriers the same amount of time to respond to a request for reconsideration of an adverse determination.

The adopted amendment to §134.600(o)(3) provides that “[i]n addition to the requirements in this section, the insurance carrier’s reconsideration procedures shall include a provision that the period during which the reconsideration is to be completed shall be based on the medical or clinical immediacy of the condition, procedure, or treatment.” This amendment is necessary to harmonize §134.600 with §10.103(b)(3) of this title (relating to Reconsideration of Adverse Determination) and to help ensure timely processing of reconsideration requests.

The adopted amendment to §134.600(o)(5) provides that a request for preauthorization for the same health care shall only be resubmitted when the requestor provides objective clinical documentation to support a substantial change in the injured employee's medical condition or objective clinical documentation that demonstrates that the injured employee has met clinical prerequisites for the requested health care that had not been met before

submission of the previous request. This amendment is necessary to clarify that requestors may resubmit a preauthorization request when an injured employee's medical condition has not substantially changed, but the injured employee has now met certain clinical prerequisites for the requested procedure that the injured employee had not met before submission of the previous request that would now make review of the medical necessity of the requested procedure appropriate. These substantial changes in course of treatment or other health care services could include, for instance, obtaining necessary psychological evaluations or an additional period of conservative care. The Division has also adopted an amendment to §134.600(o)(5) that makes it an administrative violation to frivolously resubmit a request for preauthorization for the same health care.

Amended §134.600(p). The adopted amendment to §134.600(p)(4) provides that preauthorization is required for all work hardening or work conditioning services if the proposed services are requested by a non-exempted work hardening or work conditioning program or by a Division exempted program if the services will exceed or are not addressed by the Division's treatment guidelines as described in subsection (p)(12). This amendment is necessary to clarify that the exemption provided by subsection (a)(4) only extends to work hardening or work conditioning program services insofar as those services are consistent with the Division's treatment guidelines. Amended §134.600(p) also provides that the preauthorization requirement of subsection (p)(12) does not apply to drugs prescribed for claims under §§134.506, 134.530 or 134.540 of this title (relating to Pharmaceutical Benefits). This clarifying amendment is necessary because the Division's recent amendments to §134.506 and newly adopted §134.530 and §134.540 provide that drugs prescribed under

either the Division's open or closed formulary only require preauthorization as provided by those sections.

Amended §134.600(q). The adopted amendment to §134.600(q)(2) provides that concurrent review is required for all work hardening or work conditioning services if the proposed services are requested by a non-exempted work hardening or work conditioning program or by a Division exempted program if the services will exceed or are not addressed by the Division's treatment guidelines as described in subsection (p)(12). This amendment is necessary to clarify that the exemption provided by §134.600(a)(4) only extends to work hardening or work conditioning program services insofar as those services are consistent with the Division's treatment guidelines.

Amended §134.600(t). The adopted amendment to §134.600(t) provides that an insurance carrier must maintain accurate records to reflect information regarding requests for reconsideration and requests for medical dispute resolution, in addition to information regarding requests for preauthorization or concurrent utilization, review approval/denial decisions, and appeals. This amendment is necessary to assist the Division in complying with its duties of monitoring, compilation and maintenance of statistical data, review of insurance carrier records, maintenance of an investigation unit, and medical review as required by Labor Code §§414.002, 414.003, 414.004, 414.005, and 414.007.

New §134.600(u). New §134.600(u) provides that "[for] the purposes of this section, all utilization review must be performed by an insurance carrier that is registered with or a utilization review agent that is certified by the Texas Department of Insurance to perform utilization review in accordance with Insurance Code, Chapter 4201 and Chapter 19 of this title." This amendment is necessary to clarify the application of the Insurance Code and

Department rules to utilization review under this section. New §134.600(u) also provides that “all utilization review agents or registered insurance carriers who perform utilization review under this section must comply with Labor Code §504.055 and any other provisions of Chapter 19, Subchapter U of this title (relating to Utilization Reviews for Health Care Provided under Workers' Compensation Coverage) that relate to the expedited provision of medical benefits to first responders employed by political subdivisions who sustain a serious bodily injury in course and scope of employment.” This provision is necessary to ensure that this section remains in harmony with any future rules issued by the Department on this topic while still requiring all applicable parties to comply with Labor Code §504.055.

New §134.600(v). New §134.600(v) provides a delayed effective date for this section of July 1, 2012. This delayed effective date is necessary to ensure that parties have sufficient time to evaluate and implement the new requirements of these amendments.

4. SUMMARY OF COMMENTS AND AGENCY RESPONSES.

General: A commenter applauds the Division's rulemaking process in an attempt to ensure Labor Code and House Bills are achieved as intended and agrees with many of the Division's recommendations. Another commenter states the Division is to be commended for its effort in ensuring that rules are updated to reflect the interest of various stakeholders.

Agency Response: The Division appreciates the supportive comments.

General: A commenter remarks that when treatment, service and/or medication have been identified during the retrospective review process as not medically reasonable and necessary, any continuation of that treatment, service and/or medication should be required to go through

the preauthorization or concurrent review process to ensure that the appropriate step down, transition of care, and weaning or transition is handled in the safest possible way for the injured employee.

Agency Response: The Division disagrees. Requiring health care providers to preauthorize treatments or services because an insurance carrier denied those services retrospectively for lack of medical necessity or reasonableness is administratively infeasible. If the health care provider elects to dispute the insurance carrier's retrospective denial of the medical necessity of the service(s) in question, the commenter's proposed amendment to this section would either require a health care provider to seek preauthorization for subsequent treatments on the basis of that disputed denial, which could unnecessarily delay treatment, or would delay the application of this proposed new requirement until the dispute is fully resolved by which time the course of treatment would often be complete. Furthermore, the Division notes that an insurance carrier seeking to wean or transition an injured employee's health care should be mindful that, in accordance with §134.600(n), an insurance carrier shall not condition an approval or change any elements of a preauthorization request unless the health care provider and insurance carrier mutually agree to these changes or conditions.

General: A commenter requests the Division consider the changes these amendments will require insurance carriers to implement when determining an effective date for the amendments.

Agency Response: The Division carefully reviewed and considered the additional time for system participants to prepare for implementation of this rule. The Division has determined

that July 1, 2012 is the appropriate effective date for these amendments and has incorporated this delayed effective date into new subsection (v).

General: A commenter notes that the Division has made a typographical error in its description of the proposed amendments.

Agency Response: The Division acknowledges the error.

§134.600(a)(4), (p)(4) and (q)(2): A commenter requests the requirement by rule that health care providers of work hardening certify compliance with the Division guidelines when submitting a bill or a preauthorization request.

Agency Response: The Division declines to make the suggested change for two reasons. First, comments regarding the submission of a medical bill by a health care provider are outside the scope of these amendments. Second, regarding preauthorization requests, insurance carriers already review the medical necessity of a requested service. Requiring health care providers that provide work hardening to certify compliance with the Division's treatment guidelines is, therefore, either redundant with this requirement (i.e., for services to which the Division's treatment guidelines apply) or inapplicable (i.e., for services which the health care provider asserts appropriately deviate from the Division's treatment guidelines).

§134.600(a)(7): A commenter supports the decision to change the definition of "preauthorization" in §134.600(a)(7). This definition properly reflects that preauthorization is the approval of treatment as opposed to the process of prospective utilization review.

Agency Response: The Division appreciates the supportive comment but notes there is no substantive change to the existing definition. The adopted amendments from the previous text merely reflects current Department and Division terminology relevant to “insurance carrier,” “injured employee,” and “health care provider.”

§134.600(a)(8): A commenter recommends that injured employees be added to the definition of requestor in §134.600(a)(8). The commenter acknowledges that injured employees are permitted to pursue preauthorization in the rules as proposed; however, in those instances where the injured employee pursues preauthorization it is because the health care provider requestor is not doing so. Therefore, it is more accurate and straightforward to include the injured employee as the requestor because he or she is acting in that capacity.

Agency Response: The Division declines to make the suggested change. The change is unnecessary for reasons stated by the commenter, specifically that injured employees are currently permitted to pursue preauthorization under §134.600.

§134.600(f): A commenter recommends that rule language incorporate an express requirement for all health care providers and all other requestors to submit a physical and electronic address where correspondence and explanations of benefits (EOBs) should be sent when submitting any bill, preauthorization, concurrent/retrospective request or bill for review.

Agency Response: The Division declines to make the suggested changes. Any changes regarding medical bills submitted by a health care provider are outside the scope of this rule, which only addresses preauthorization and concurrent review. Additionally, the Division finds

no persuasive rationale for requiring requestors under §134.600(f) to include a physical address in their preauthorization, concurrent review, and voluntary certification, and physical correspondence at this time appears infeasible in light of the deadlines for preauthorization and concurrent review determinations and notices.

§134.600(f): Commenters recommend an amendment stating that in the absence of the required data elements, the insurance carrier shall process the preauthorization request, or in the alternative, amend the rule to address what action an insurance carrier should take if a required element is not included in the request for preauthorization or concurrent review. It is recommended that the Division promulgate a standard request for preauthorization or concurrent review form that is pre-populated with blanks for the required elements. A commenter believes a standardized format will assist the requestor in providing all necessary information and will help the insurance carrier identify the communication as a request for preauthorization or concurrent review.

Agency Response: The Division declines to make the suggested change or to promulgate a new form. Pursuant to §134.600, insurance carriers must review all preauthorization requests solely on the basis of the medical necessity of the services. Insurance carriers do not review preauthorization requests on the basis of compliance with §134.600(f). If the insurance carrier, therefore, determines that the request fails to substantiate the medical necessity of the requested service and cannot remedy these defects through discussion with the health care provider under §134.600(m), the insurance carrier should deny the request. Furthermore, if the insurance carrier believes the requestor has failed to comply with §134.600, the insurance carrier may submit a complaint to the Division regarding this noncompliance.

§134.600(f)(6): A commenter states that including the requestor and requestor's professional license number or national provider identifier or injured employee's name if the injured employee is requesting preauthorization on a preauthorization request is of great help to the utilization review agent. The commenter notes, however, that this amendment will delay requests, and when the requestor is not the same as the proposed health care provider, the requestor may not have this information. The commenter also inquires if this then will limit the responsibility of the treating doctor who is required to be the ultimate responsible party for the injured employee's care, and coordination of said care as stated in the Division's Chapter 180 rules.

Agency Response: The Division disagrees that this amendment will lead to delayed requests beyond minimal initial delays while requestors adapt to the Division's new requirements for preauthorization requests. Further, the Division clarifies that these amendments are necessary for proper identification of all parties to the request and to ensure the appropriate review of the request. The Division also notes that this additional information aids the utilization review agent in the approval process, because it identifies who the direct health care provider is and provides more detail as to the service or treatment. Lastly, the Division additionally clarifies that this new data element does nothing to modify the responsibilities of any health care provider in the workers' compensation system. The roles and responsibilities of the various health care providers in the Texas workers' compensation system are detailed in §180.22 of this title (relating to Health Care Provider Roles and Responsibilities) and other applicable provisions of the Act and Division rules.

§134.600(f)(6) and (f)(7): A commenter is concerned that the proposed addition to add the requestor's professional license number or national provider identifier (NPI) and the facility's NPI to the request will require capturing that information for reporting purposes later. The commenter states that currently the commenter's system only has a field for the requesting health care provider's federal employer identification number (FEIN). It is particularly concerning that it appears the Division is moving away from the FEIN number. If it is the intent of the rule that the Division will require insurance carriers to capture that information, then consideration of adequate time to implement the changes would be necessary to ensure compliance. In addition, the commenter would like it noted that this would cause additional costs for re-programming an existing system.

Agency Response: The Division clarifies that a health care provider's FEIN has never been a required element of a preauthorization request, and, therefore, the Division is not moving away from this element. Furthermore, the Division clarifies that the new requirement for a health care provider identifier is intended to specifically identify the health care provider requesting preauthorization. The Division notes that Labor Code §413.011, in pertinent part, requires the Division to adopt the most current reimbursement methodologies used by the federal Centers for Medicare and Medicaid Services (CMS), including applicable coding policies. Title 45, Code of Federal Regulations (CFR) §162.406 specifically adopts the NPI as the standard unique health identifier for health care providers. Individual health care providers may not have a federal employer identification number FEIN and their tax identification number may not appear on the medical bill submitted after the health care services are rendered. The NPI is required to be contained on the medical bill and the use of

the NPI is a more efficient and effective means to ensure the appropriate review of services subject to preauthorization.

Lastly, the Division notes that a health care provider's NPI number is already required to be reported for medical state reporting purposes in accordance with Subchapter I of Chapter 134 of this title (relating to Medical Bill Reporting).

§134.600(h): A commenter recommends that subsection (h) be modified to require the insurance carrier to specifically consider unresolved issues of compensability, extent of or relatedness to the compensable injury, and the insurance carrier's liability for the injury in reviewing preauthorization requests. The commenter recommends that the insurance carrier be required to raise challenges to compensability and relatedness in addition to raising any challenge to whether the proposed treatment is health care reasonably required in the preauthorization process. This would make a preauthorization determination more closely mirror a preauthorization determination in group health and would help reduce the hassle factor that is often cited by health care providers as a reason for their reluctance to participate in the Texas workers' compensation system.

Agency Response: The Division disagrees with the commenter's suggested change. The timelines for an insurance carrier to deny a claim or medical bill on the basis of compensability or extent of injury are governed by Labor Code §409.021 and §408.027, respectively, and cannot be modified by the preauthorization process. The Division does clarify, however, that subsection (l)(3) requires an insurance carrier to include in an approval a notice of any unresolved dispute regarding the denial of compensability or liability or an unresolved dispute of extent or relatedness to the compensable injury.

§134.600(o): Commenters state that the Division's amendments to this subsection effectively extend the preauthorization process to 60 days, which could delay care and require physicians to deviate from the required clinical timeframes of the *Official Disability Guidelines*.

Agency Response: The Division disagrees with the commenter's predicted results of the effective extension of the preauthorization process to 60 days. The preauthorization and request for reconsideration process could only extend to 60 days if both the health care provider takes 30 days to submit a request for reconsideration and the insurance carrier takes 30 days to process the request. In some cases, however, these durations may be appropriate, and Insurance Code §4201.359 provides insurance carriers this timeframe to respond to request for reconsideration, if necessary. If a health care provider believes, however, that an insurance carrier has unnecessarily delayed review of a request for reconsideration, the health care provider should file a complaint with the Division.

§134.600(o)(2)(A): Commenters object to extending the deadline for an insurance carrier to respond to a request for reconsideration from 5 days to 30 days and question the Division justification for this change. The commenters provide various rationales for their disagreement, including but not limited to: (1) objecting to the Division's stated reason of harmonization with certified network rules, because health care providers who agree to join a network do so with an agreement to abide by the network's rules; (2) the relatively short timeframe it takes to review a request; and (3) most requests already take the maximum amount of time to respond and this deadline extension will only exacerbate this practice and further delay treatments and services for injured employees.

Agency Response: The Division disagrees with commenters' objections and does not modify the proposed extended deadline for review of a request of reconsideration of a denied preauthorization request. As stated in the Division's proposal of this amended section, this amendment is necessary to comply with Insurance Code §4201.359. Furthermore, the Division notes that this deadline also harmonizes non-network and network care and that this deadline has been successfully implemented in the network context.

§134.600(o)(2)(A): A commenter states that the wording "as soon as practicable" is ambiguous. The commenter asks how this will be measured and who decides what is practicable.

Agency Response: The Division declines to define the term because what is "as soon as practicable" must be determined on a case-by-case basis. The Division also clarifies that the ultimate 30 day deadline to review all requests for reconsideration provides an objective deadline that will limit disputes as to the practicality of a particular review. If a health care provider believes, however, that an insurance carrier has unnecessarily delayed review of a request for reconsideration, the health care provider should file a complaint with the Division.

§134.600(o)(3): A commenter notes that there is no definition of "clinical immediacy." This could cause conflicts in interpretation of how long a particular preauthorization reconsideration request should take.

Agency Response: The Division acknowledges that parties could potentially disagree over "clinical immediacy" of a particular request for reconsideration, but this disagreement would not necessarily be cured by a definition of the term. Furthermore, because this term

originates in Insurance Code, Chapters 1305 and 4201, it is more properly defined, if necessary, in the context of rule proposals directly relating to that chapter. Lastly, the Division notes that if a health care provider believes that an insurance carrier has unnecessarily delayed review of a request for reconsideration, the health care provider should file a complaint with the Division.

§134.600(o)(3): A commenter states the Legislature has created only one factor to consider regarding the necessity of expedited utilization review for Chapter 1305 networks: whether or not the review pertains to an emergency and thus requires no preauthorization. Creating additional factors for networks based on “immediacy” applies non-applicable Chapter 4201 standards onto Chapter 1305 networks, in violation of §1305.351(a).

Agency Response: The commenter’s concerns are directed to the Insurance Code and its applicability to Certified Workers’ Compensation Health Care Networks. Section 134.600 does not apply to Certified Workers’ Compensation Health Care Networks.

§134.600(o)(5): Commenters support this change and believe it will be beneficial to all system participants. A commenter states this inclusion is an important change that will serve to ameliorate the unintended consequences of the requirement to prove a substantial change in the injured employee's medical condition before a preauthorization request can be resubmitted and will result in additional necessary health care being provided to injured employees.

Agency Response: The Division appreciates the supportive comment.

§134.600(o)(5): A commenter recommends that the Division clarify that if the requestor submits the additional information to the insurance carrier during the 30 day reconsideration period the insurance carrier may process the documents as a request for reconsideration rather than a resubmission.

Agency Response: The Division declines to make the commenter's suggested clarification. A resubmission of a preauthorization request on the basis of a change in clinical circumstances is not requesting an insurance carrier to reconsider its previous adverse determination or disputing that adverse determination but instead is requesting an insurance carrier to issue a new decision based on the clinical prerequisites met that had not been met before the previous request. The Division further clarifies that resubmission of a preauthorization under this exception is distinct from a scenario in which a health care provider had met all applicable clinical prerequisites for a requested procedure before submitting a preauthorization request but failed to document that these prerequisites had been met. In this scenario, it would be appropriate to submit the additional documentation of the already completed prerequisites through the reconsideration process.

§134.600(o)(5): A commenter states this additional information is much appreciated, and requests clarification as to what constitutes a "frivolous resubmission."

Agency Response: The Division notes that any determination of frivolity must be made on a case-by-case basis but also points the commenter to §180.1(12) of this title (relating to Definitions), which defines "frivolous" as "that which does not have a basis in fact or is not warranted by existing law or a good faith argument for the extension, modification, or reversal of existing law."

§134.600(p)(4)(B): A commenter commends the clarification provided ensuring that services that will exceed or are not addressed by the Division's treatment guidelines be a requirement for preauthorization.

Agency Response: The Division appreciates the supportive comment but notes that this is an existing requirement not modified by these amendments.

§134.600(p)(11): Regarding chronic injuries, a commenter recommends where the procedure summary differs from the formulary determination of "Yes" or "No" for a drug, clarification of whether the formulary or body part chapter procedure summary recommendation for a drug takes precedence would be beneficial. The commenter further suggests that consideration be given to eliminating possible discrepancies by designating all such drugs as "No" drugs in the formulary.

Agency Response: The Division notes that these comments pertaining to the Division's pharmacy closed formulary are outside the scope of the proposed rules.

§134.600(p)(12): A commenter suggests the addition of this requirement of not applying to drugs prescribed for claims under §§134.506, 134.530 or 134.540 of this title (relating to Pharmaceutical Benefits) will potentially create confusion.

Agency Response: The Division disagrees. The clarifying amendment is necessary because the Division's recent amendments to §134.506 and adopted new §134.530 and §134.540 of this title provide that drugs prescribed under either the Division's open or closed formulary only require preauthorization as provided by those sections. Without such a

provided reference in this subchapter pertaining to prospective and concurrent review of health care, a system participant might not realize that separate and more specific preauthorization requirements exist in a separate subchapter pertaining to pharmaceutical benefits.

§134.600(p)(12): Commenters recommend deletion of the last sentence of the proposed rule.

This prescription drug exemption is inappropriate in the closed formulary rules and is inappropriate in the preauthorization rule. The purpose of preauthorization is to protect the injured employee from adverse health outcomes that result from inappropriate medical care and to alleviate the Texas workers' compensation system from unnecessary costs.

Pharmaceutical services including prescription drugs should be subject to preauthorization if the prescription exceeds or is not addressed by the adopted treatment guidelines.

Agency Response: The Division disagrees and declines to make the recommended changes because these adopted changes to subsection (p)(12) are specifically made for the purpose of conforming to the existing requirement of adopted pharmacy formulary rules and cannot be modified without modification of those rules as well. For further explanation of the rationale for this preauthorization policy, the Division directs the commenters to the Division's rationale preamble to the adoption of the pharmacy formulary published at 35 TexReg 11344. The Division also clarifies, however, that regardless of the preauthorization requirements, current Division rules require pharmaceutical services to be provided in accordance with the Division's treatment guidelines. All current prescribing practices, therefore, should be conforming to these treatment guidelines.

§134.600(u): A commenter notes that the provisions of Labor Code §504.011(c), as added by House Bill 2605, applies to specific insurance carriers that handle political subdivision first responder serious bodily injury claims, as opposed to all carriers in the State of Texas.

Requiring all utilization review agents and insurance carriers in the state to have written policies to comply with provisions of Chapter 504 appears to exceed the statutory scope.

Agency Response: The Division disagrees that these provisions exceed the statutory scope. The Division has, nonetheless, made a change to this proposed subsection in order to ensure that this rule harmonizes with any future amendments to the Department's rules regarding this issue.

§134.600(u): A commenter is unsure what proposed language, "expedited provision of medical benefits" means in regards to timeframes for reviewing preauthorization, concurrent review, and reconsideration requests. This verbiage is vague and subjective.

Agency Response: The Division notes that the concept of "expedited provision of medical benefits" is included in Labor Code §504.055, and declines to further define the terms.

Section 504.055(c) specifically directs the political subdivision, Division, and insurance carrier to accelerate and give priority to an injured first responder's claim for medical benefits.

5. NAMES OF THOSE COMMENTING FOR AND AGAINST THE SECTION.

For: none.

For, with changes: Coventry Workers' Comp. Services, Insurance Council of Texas, Review Med, and Texas Mutual Insurance Company.

Against: none

Neither for or against, with changes: Office of Injured Employee Counsel, Property Casualty Insurers Association of America, State Office of Risk Management, and Texas Association of School Boards Risk Management Fund.

6. STATUTORY AUTHORITY.

The amendments are adopted under the Labor Code §§408.021, 413.014, and 504.055, Insurance Code §§1305.354, 4201.054, and 4201.359, and Government Code §2001.036 and under the general authority of §402.00128 and §402.061. In relevant part, Labor Code §408.021 provides that an employee who sustains a compensable injury is entitled to all health care reasonably required by the nature of the injury as and when needed and is specifically entitled to health care that: (1) cures or relieves the effects naturally resulting from the compensable injury; (2) promotes recovery; or (3) enhances the ability of the employee to return to or maintain employment. Labor Code §413.014 provides that the commissioner by rule shall specify which health care treatments and services require express preauthorization or concurrent review by the insurance carrier. Labor Code §504.055 provides, in relevant part, that insurance carriers and political subdivisions shall accelerate and give priority to an injured first responder's claim for medical benefits. Insurance Code §1305.354 provides that a utilization review agent's procedures for review of reconsideration of an adverse determination must include written notification to the requesting party of the determination of the request for reconsideration as soon as practicable, but not later than the 30th day after the utilization review agent received the request. Insurance Code §4201.054 provides that the requirements of Chapter 4201 apply to utilization review of a health care services provided to a person eligible for workers' compensation medical benefits under Title

5, Labor Code. Insurance Code §4201.359 provides that a utilization review agent's procedures for review of reconsideration of an adverse determination must include written notification of determination of the appeal to the requesting party as soon as practicable, but not later than the 30th day after the utilization review agent received the request.

Government Code §2001.036 provides, in relevant part, a rule takes effect 20 days after the date on which it is filed in the office of the secretary of state, except that if a later date is specified in the rule, the late date is the effective date.

Section 402.00128 lists the general powers of the Commissioner, including the power to hold hearings. Section 402.061 provides that the Commissioner shall adopt rules as necessary for the implementation and enforcement of this subtitle.

7. TEXT.

§134.600. *Preauthorization, Concurrent Review, and Voluntary Certification of Health Care.*

(a) The following words and terms when used in this chapter shall have the following meanings, unless the context clearly indicates otherwise:

(1) Ambulatory surgical services: surgical services provided in a facility that operates primarily to provide surgical services to patients who do not require overnight hospital care.

(2) Concurrent review: a review of on-going health care listed in subsection (q) of this section for an extension of treatment beyond previously approved health care listed in subsection (p) of this section.

(3) Diagnostic study: any test used to help establish or exclude the presence of disease/injury in symptomatic individuals. The test may help determine the diagnosis, screen

for specific disease/injury, guide the management of an established disease/injury, and formulate a prognosis.

(4) Division exempted program: a Commission on Accreditation of Rehabilitation Facilities (CARF) accredited work conditioning or work hardening program that has requested and been granted an exemption by the division from preauthorization and concurrent review requirements except for those provided by subsections (p)(4) and (q)(2) of this section.

(5) Final adjudication: the commissioner has issued a final decision or order that is no longer subject to appeal by either party.

(6) Outpatient surgical services: surgical services provided in a freestanding surgical center or a hospital outpatient department to patients who do not require overnight hospital care.

(7) Preauthorization: prospective approval obtained from the insurance carrier by the requestor or injured employee prior to providing the health care treatment or services (health care).

(8) Requestor: the health care provider or designated representative, including office staff or a referral health care provider/health care facility that requests preauthorization, concurrent review, or voluntary certification.

(9) Work conditioning and work hardening: return-to-work rehabilitation programs as defined in this chapter.

(b) When division-adopted treatment guidelines conflict with this section, this section prevails.

(c) The insurance carrier is liable for all reasonable and necessary medical costs relating to the health care:

(1) listed in subsection (p) or (q) of this section only when the following situations occur:

(A) an emergency, as defined in Chapter 133 of this title (relating to General Medical Provisions);

(B) preauthorization of any health care listed in subsection (p) of this section that was approved prior to providing the health care;

(C) concurrent review of any health care listed in subsection (q) of this section that was approved prior to providing the health care; or

(D) when ordered by the commissioner;

(2) or per subsection (r) of this section when voluntary certification was requested and payment agreed upon prior to providing the health care for any health care not listed in subsection (p) of this section.

(d) The insurance carrier is not liable under subsection (c)(1)(B) or (C) of this section if there has been a final adjudication that the injury is not compensable or that the health care was provided for a condition unrelated to the compensable injury.

(e) The insurance carrier shall designate accessible direct telephone and facsimile numbers and may designate an electronic transmission address for use by the requestor or injured employee to request preauthorization or concurrent review during normal business hours. The direct number shall be answered or the facsimile or electronic transmission address responded to by the insurance carrier within the time limits established in subsection (i) of this section.

(f) The requestor or injured employee shall request and obtain preauthorization from the insurance carrier prior to providing or receiving health care listed in subsection (p) of this

section. Concurrent review shall be requested prior to the conclusion of the specific number of treatments or period of time preauthorized and approval must be obtained prior to extending the health care listed in subsection (q) of this section. The request for preauthorization or concurrent review shall be sent to the insurance carrier by telephone, facsimile, or electronic transmission and, include the:

- (1) name of the injured employee;
- (2) specific health care listed in subsection (p) or (q) of this section;
- (3) number of specific health care treatments and the specific period of time requested to complete the treatments;
- (4) information to substantiate the medical necessity of the health care requested;
- (5) accessible telephone and facsimile numbers and may designate an electronic transmission address for use by the insurance carrier;
- (6) name of the requestor and requestor's professional license number or national provider identifier, or injured employee's name if the injured employee is requesting preauthorization;
- (7) name, professional license number or national provider identifier of the health care provider who will render the health care if different than paragraph (6) of this subsection and if known;
- (8) facility name, and the facility's national provider identifier if the proposed health care is to be rendered in a facility; and
- (9) estimated date of proposed health care.

(g) A health care provider may submit a request for health care to treat an injury or diagnosis that is not accepted by the insurance carrier in accordance with Labor Code §408.0042.

(1) The request shall be in the form of a treatment plan for a 60 day timeframe.

(2) The insurance carrier shall review requests submitted in accordance with this subsection for both medical necessity and relatedness.

(3) If denying the request, the insurance carrier shall indicate whether the denial is based on medical necessity and/or unrelated injury/diagnosis in accordance with subsection (m) of this section.

(4) The requestor or injured employee may file an extent of injury dispute upon receipt of an insurance carrier's response which includes a denial due to unrelated injury/diagnosis, regardless of the issue of medical necessity.

(5) Requests which include a denial due to unrelated injury/diagnosis may not proceed to medical dispute resolution based on the denial of unrelatedness. However, requests which include a denial based on medical necessity may proceed to medical dispute resolution for the issue of medical necessity in accordance with subsection (o) of this section.

(h) Except for requests submitted in accordance with subsection (g) of this section, the insurance carrier shall approve or deny requests based solely upon the medical necessity of the health care required to treat the injury, regardless of:

(1) unresolved issues of compensability, extent of or relatedness to the compensable injury;

(2) the insurance carrier's liability for the injury; or

(3) the fact that the injured employee has reached maximum medical improvement.

(i) The insurance carrier shall contact the requestor or injured employee by telephone, facsimile, or electronic transmission with the decision to approve or deny the request as follows:

(1) within three working days of receipt of a request for preauthorization; or

(2) within three working days of receipt of a request for concurrent review, except for health care listed in subsection (q)(1) of this section, which is due within one working day of the receipt of the request.

(j) The insurance carrier shall send written notification of the approval or denial of the request within one working day of the decision to the:

(1) injured employee;

(2) injured employee's representative; and

(3) requestor, if not previously sent by facsimile or electronic transmission.

(k) The insurance carrier's failure to comply with any timeframe requirements of this section shall result in an administrative violation.

(l) The insurance carrier shall not withdraw a preauthorization or concurrent review approval once issued. The approval shall include:

(1) the specific health care;

(2) the approved number of health care treatments and specific period of time to complete the treatments; and

(3) a notice of any unresolved dispute regarding the denial of compensability or liability or an unresolved dispute of extent of or relatedness to the compensable injury.

(m) The insurance carrier shall afford the requestor a reasonable opportunity to discuss the clinical basis for a denial with the appropriate doctor or health care provider performing the review prior to the issuance of a preauthorization or concurrent review denial. The denial shall include:

- (1) the clinical basis for the denial;
- (2) a description or the source of the screening criteria that were utilized as guidelines in making the denial;
- (3) the principle reasons for the denial, if applicable;
- (4) a plain language description of the complaint and appeal processes, if denial was based on Labor Code §408.0042, include notification to the injured employee and health care provider of entitlement to file an extent of injury dispute in accordance with Chapter 141 of this title (relating to Dispute Resolution--Benefit Review Conference); and
- (5) after reconsideration of a denial, the notification of the availability of an independent review.

(n) The insurance carrier shall not condition an approval or change any elements of the request as listed in subsection (f) of this section, unless the condition or change is mutually agreed to by the health care provider and insurance carrier and is documented.

(o) If the initial response is a denial of preauthorization or concurrent review, the requestor or injured employee may request reconsideration.

(1) The requestor or injured employee may within 30 days of receipt of a written initial denial request the insurance carrier to reconsider the denial and shall document the reconsideration request.

(2) The insurance carrier shall respond to the request for reconsideration of the denial:

(A) as soon as practicable but not later than the 30th day after receiving a request for reconsideration of denied preauthorization; or

(B) within three working days of receipt of a request for reconsideration of denied concurrent review, except for health care listed in subsection (q)(1) of this section, which is due within one working day of the receipt of the request.

(3) In addition to the requirements in this section, the insurance carrier's reconsideration procedures shall include a provision that the period during which the reconsideration is to be completed shall be based on the medical or clinical immediacy of the condition, procedure, or treatment.

(4) The requestor or injured employee may appeal the denial of a reconsideration request regarding medical necessity by filing a dispute in accordance with Labor Code §413.031 and related division rules.

(5) A request for preauthorization for the same health care shall only be resubmitted when the requestor provides objective clinical documentation to support a substantial change in the injured employee's medical condition or that demonstrates that the injured employee has met clinical prerequisites for the requested health care that had not been previously met before submission of the previous request. The insurance carrier shall review the documentation and determine if any substantial change in the injured employee's medical condition has occurred or if all necessary clinical prerequisites have been met. A frivolous resubmission of a preauthorization request for the same health care constitutes an administrative violation.

(p) Non-emergency health care requiring preauthorization includes:

(1) inpatient hospital admissions, including the principal scheduled procedure(s) and the length of stay;

(2) outpatient surgical or ambulatory surgical services as defined in subsection (a) of this section;

(3) spinal surgery;

(4) all work hardening or work conditioning services requested by:

(A) non-exempted work hardening or work conditioning programs; or

(B) division exempted programs if the proposed services exceed or are not addressed by the division's treatment guidelines as described in paragraph (12) of this subsection;

(5) physical and occupational therapy services, which includes those services listed in the Healthcare Common Procedure Coding System (HCPCS) at the following levels:

(A) Level I code range for Physical Medicine and Rehabilitation, but limited to:

(i) Modalities, both supervised and constant attendance;

(ii) Therapeutic procedures, excluding work hardening and work conditioning;

(iii) Orthotics/Prosthetics Management;

(iv) Other procedures, limited to the unlisted physical medicine and rehabilitation procedure code; and

(B) Level II temporary code(s) for physical and occupational therapy services provided in a home setting;

(C) except for the first six visits of physical or occupational therapy following the evaluation when such treatment is rendered within the first two weeks immediately following:

(i) the date of injury, or

(ii) a surgical intervention previously preauthorized by the insurance carrier;

(6) any investigational or experimental service or device for which there is early, developing scientific or clinical evidence demonstrating the potential efficacy of the treatment, service, or device but that is not yet broadly accepted as the prevailing standard of care;

(7) all psychological testing and psychotherapy, repeat interviews, and biofeedback, except when any service is part of a preauthorized or division exempted return-to-work rehabilitation program;

(8) unless otherwise specified in this subsection, a repeat individual diagnostic study:

(A) with a reimbursement rate of greater than \$350 as established in the current Medical Fee Guideline; or

(B) without a reimbursement rate established in the current Medical Fee Guideline;

(9) all durable medical equipment (DME) in excess of \$500 billed charges per item (either purchase or expected cumulative rental);

(10) chronic pain management/interdisciplinary pain rehabilitation;

(11) drugs not included in the applicable division formulary;

(12) treatments and services that exceed or are not addressed by the commissioner's adopted treatment guidelines or protocols and are not contained in a treatment plan preauthorized by the insurance carrier. This requirement does not apply to drugs prescribed for claims under §§134.506, 134.530 or 134.540 of this title (relating to Pharmaceutical Benefits);

(13) required treatment plans; and

(14) any treatment for an injury or diagnosis that is not accepted by the insurance carrier pursuant to Labor Code §408.0042 and §126.14 of this title (relating to Treating Doctor Examination to Define the Compensable Injury).

(q) The health care requiring concurrent review for an extension for previously approved services includes:

(1) inpatient length of stay;

(2) all work hardening or work conditioning services requested by:

(A) non-exempted work hardening or work conditioning programs; or

(B) division exempted programs if the proposed services exceed or are

not addressed by the division's treatment guidelines as described in subsection (p)(12) of this section;

(3) physical and occupational therapy services as referenced in subsection (p)(5) of this section;

(4) investigational or experimental services or use of devices;

(5) chronic pain management/interdisciplinary pain rehabilitation; and

(6) required treatment plans.

(r) The requestor and insurance carrier may voluntarily discuss health care that does not require preauthorization or concurrent review under subsections (p) and (q) of this section respectively.

(1) Denial of a request for voluntary certification is not subject to dispute resolution for prospective review of medical necessity.

(2) The insurance carrier may certify health care requested. The carrier and requestor shall document the agreement. Health care provided as a result of the agreement is not subject to retrospective review of medical necessity.

(3) If there is no agreement between the insurance carrier and requestor, health care provided is subject to retrospective review of medical necessity.

(s) An increase or decrease in review and preauthorization controls may be applied to individual doctors or individual workers' compensation claims, by the division in accordance with Labor Code §408.0231(b)(4) and other sections of this title.

(t) The insurance carrier shall maintain accurate records to reflect information regarding requests for preauthorization, or concurrent review approval/denial decisions, and appeals, including requests for reconsideration and requests for medical dispute resolution, if any. The insurance carrier shall also maintain accurate records to reflect information regarding requests for voluntary certification approval/denial decisions. Upon request of the division, the insurance carrier shall submit such information in the form and manner prescribed by the division.

(u) For the purposes of this section, all utilization review must be performed by an insurance carrier that is registered with, or a utilization review agent that is certified by, the Texas Department of Insurance to perform utilization review in accordance with Insurance

Code, Chapter 4201 and Chapter 19 of this title (relating to Agents' Licensing). Additionally, all utilization review agents or registered insurance carriers who perform utilization review under this section must comply with Labor Code §504.055 and any other provisions of Chapter 19, Subchapter U of this title (relating to Utilization Reviews for Health Care Provided under Workers' Compensation Insurance Coverage) that relate to the expedited provision of medical benefits to first responders employed by political subdivisions who sustain a serious bodily injury in course and scope of employment.

(v) This section is effective July 1, 2012.

8. CERTIFICATION.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's authority to adopt.

Issued at Austin, Texas, on the 26th day of March, 2012.

X

Dirk Johnson
General Counsel
Texas Department of Insurance,
Division of Workers' Compensation

IT IS THEREFORE THE ORDER of the Commissioner of Workers' Compensation that §134.600 specified herein, concerning preauthorization, concurrent review, and voluntary certification of health care, is adopted.

Rod Bordelon
Commissioner of Workers'
Compensation

ATTEST:

Dirk Johnson
General Counsel
Texas Department of Insurance,
Division of Workers' Compensation

COMMISSIONER ORDER NO _____